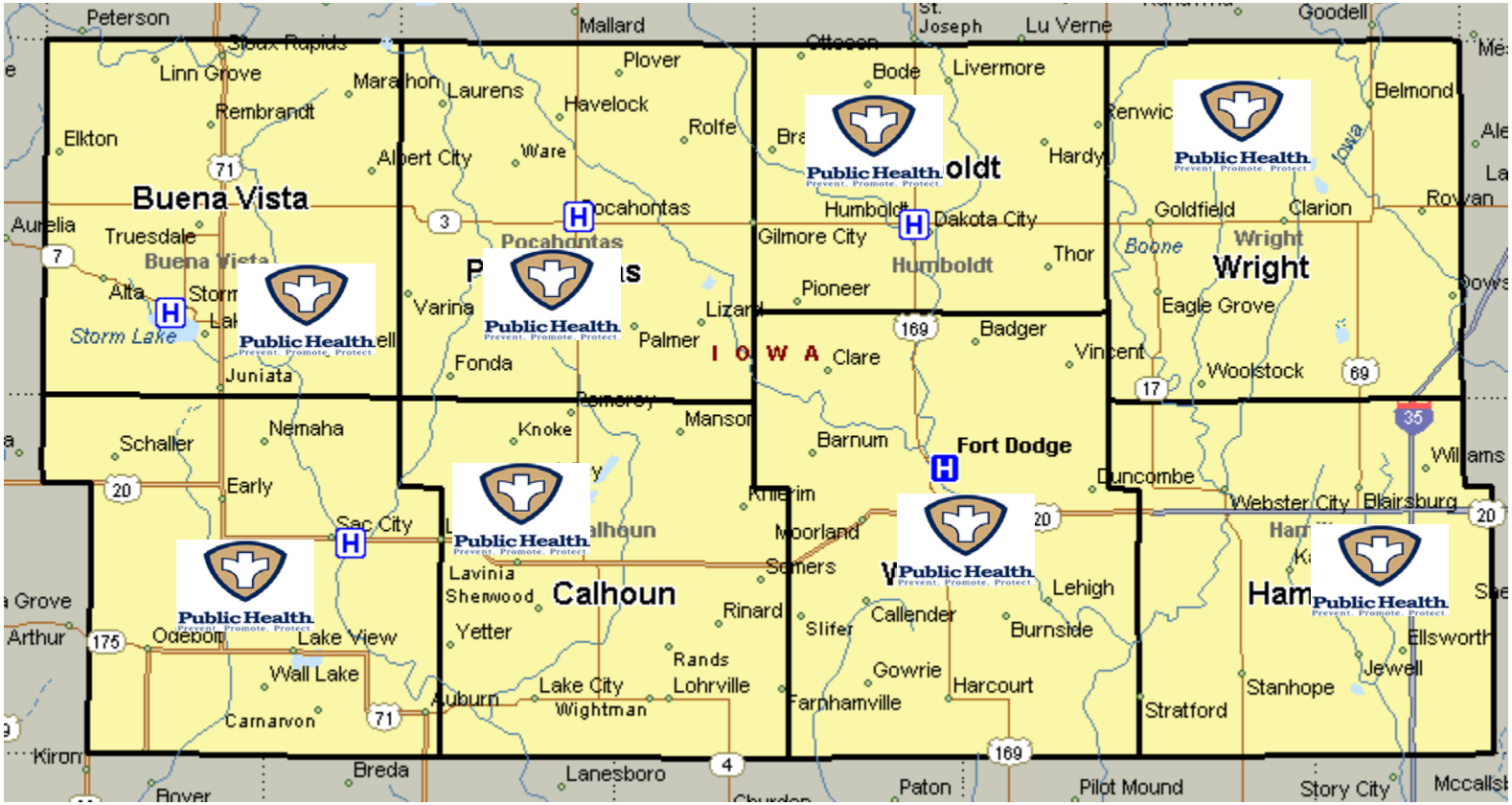
Public Health services integrated into the Pioneer ACO

- 8-county service area in Northwest Central Iowa



Public Health
Prevent. Promote. Protect.

What does each public health agency already provide in this "regional" Pioneer ACO area?
Can our public health departments "braid" our services together and be integrated into the Pioneer ACO and focus on population and community services?

- **Title V Maternal / Child Health**
- Health Maintenance/Health Promotion Visits
- 0-3 years of age- Early Childhood Iowa – home visitation services for parenting skills and development
- Childhood Lead Prevention
- Public health emergency and response; mass immunizations to children and adults
- Breast and cervical cancer early detection
- Women Infant and Children (WIC) nutrition
- Child Care Nurse Consultants
- Environmental Health
- Tobacco prevention
- Chronic Disease Programs

AIM: Leverage every aspect of our “community” to achieve Best Outcome for Every Patient Every Time

Triple Aim Goals:

Better care for individuals

Better health for populations

Reduced healthcare expenditures

UnityPoint Health

Model Trinity Pioneer ACO – Achieving our Aim

AIM: Leverage every aspect of our "community" to achieve Best Outcome for Every Patient Every Time

Primary Care Community

Primary Drivers

Secondary Drivers

Promote and Maintain Health	Prevent Illness and Disability	Provide a Coordinated Care Experience	Manage Population Health	Support Choice Through the Lifespan
• Health-Risk Assessment • Iowa's Healthiest State initiative • Preventive screening • Health Education and Literacy • Wellness Program	• Patient access to PCP • Common screening and assessment tools • Single, patient-centric care plan • Med Therapy Management • Mental Health Action Team	• Care transitions – Extended Care Facilities • ICCDM – all care settings • Advanced Medical Team • Telephonic-Telemonitoring • Strategic Healthcare Partners • Critical Access Hospitals	• Risk stratification • Med Therapy Management • Disease Management Coaching • Strategic Community Partners	Palliative Care: • Inpatient • Home-based • Clinic • Integration with PCP Hospice: • Hospice Home • Home-based

Home/Neighborhood - Schools - Business - Healthcare Agencies - Government -Recreation - Church/Spiritual

Public Health Lifespan Timeline

Promote and Maintain Health | Prevent Illness and Disability | Provide a Coordinated Care Experience | Manage Population Health | Support Choice Through the Lifespan

Preconception

- Family Foundations (Home Visits)
- Family Planning Network
- Preventative Screenings
- Teen Information Pregnancy Prevention Program
- Women Infants and Children Program (WIC)

Maternal & Fetal

- Care Coordination (Face to Face, Phone & Home Visits)
- Dietitian Home Visits
- Family Foundations (Home Visits)
- Family Planning Network
- Health Education
- Immunizations-
  - Flu
  - Hepatitis A
  - Hepatitis B
- Interpretation Services
- Oral Health
- Presumptive Eligibility
- Preventative screenings
- Risk Assessment
- Skilled Nursing Home Visits
- Social Worker Home Visits
- Tobacco Counseling
- Transportation Services
- WIC/Farmers Market

Newborn/Child

- Care Coordination (Face to Face, Phone & Home Visits)
- Developmental Screening
- Dietitian Home Visits
- Family Foundations (Home Visits)
- hawki Outreach
- Home Inspections for Lead Based Paint (EBL Children)
- Immunizations
- Informing/Re-informing (T19 Eligible)
- Interpretation Services
- Lead Testing & Follow-up
- Oral Health Services
- Presumptive Eligibility
- Preventative screenings
- Skilled Nursing Visits
- Social Worker Home Visit
- Transportation Services
- Well Testing
- WIC/Farmers Market

Adolescent

- Care Coordination (Face to Face, Phone & Home Visits)
- Dietitian
- hawki
- HIV Case Management
- Immunizations
- Oral Health
- Presumptive Eligibility
- Preventative screenings
- Skilled Nursing Services
- Social Workers
- STD Testing
- Teen Information Pregnancy Prevention Program
- Tobacco Prevention Education

Adult

- Breast & Cervical Cancer Early Detection Program (BCCEDP)
- Care Coordination (Face to Face, Phone & Home Visits)
- Child Care Nurse Consultant
- Health Promotion home visits
- Chronic Disease Self-Management Program (CDSMP)
- HIV Case Management
- Immunizations
- Preventative screenings
- Skilled Nursing Services
- STD Testing

Elderly

- Care Coordination (Face to Face, Phone & Home Visits)
- Chronic Disease Self-Management Program (CDSMP)
- Foot Care Clinics
- Health Promotion home visits
- Immunizations
- Preventative screenings
- Senior Health Clinics
- Skilled Nursing Services

Community Health Services

- Bio & Emergency Preparedness
- Chef Charles
- Child Care Nurse Consultant
- Communicable Disease
- Community Transformation Grant
  - Tobacco Free Living
  - Active living & Health Eating
  - Safe & Healthy Environments
  - Healthy Workplace
- CPR and First Aid Training
- Environmental Health Education & Complaint Follow-up

Last Updated 04/04/2013

- Health Promotion and Maintenance Visits
- Home Care Aide Services (Homemaker & Personal Care)
- Population Immunization Clinics (Flu, Tdap)
- Pool Inspections
- Radon Testing and Education
- Septic Permits
- SNAP Basics Nutrition Programs (School)
- Tanning Establishment Inspections
- Tattoo Establishment Inspections
- Tobacco Prevention Education, Quitline Referral & Smoking Cessation Programs
- Well Permits
- Well Water Testing

Referrals to other community based services

Webster County Public Health

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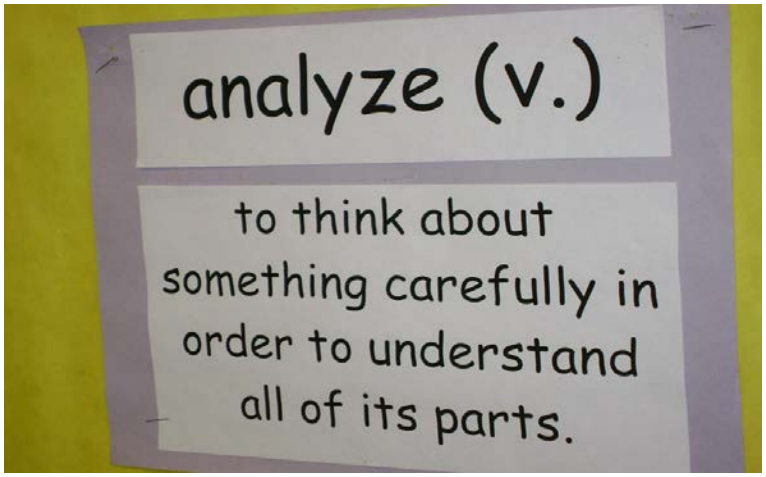

- How can we “mirror” our MCH Program -
- Analyzing local county public health departments
- Structure
- Services already coordinated
- Relationships already established
- Capacity to provide additional services
- Existing/opportunities for future alliances for services

Quick Wins: Integrating Public Health Services into the ACO

- Unified assessments: fall assessments, mental health screenings
- Common patient centered care plan – Central Intake
- **Title V Maternal/Child Health Program -working well – mirror this program**
- WIC Program
- Better Choice Better Health – Community Transformation Grant
- Pilot Project with Pediatric doctors
- Asthma Project – year 2
- Influenza with children and adults – NPI # for Public Health Departments
- Depression screenings – year 2
- Well Child
- Tobacco Use Assessment/Cessation Intervention
- Pneumococcal vaccinations
- Senior Health Program
- Public Health Community Health Programs (health maintenance and promotion)
- ER Discharges referrals to public health programs

Integration ~ Speaking a Common Language

Steering Committee
Promote/Maintain Health

Prevent Illness/Disability

Coordinate Care Experience

Manage Population Health

Support Choice through lifespan

Trinity Pioneer
ICCDM, HRA

My Care Profile

Unity Point at Home
MTM
ER Discharge

Long term Care
Readmission work
Telephonic Disease Mgmt

AMT
Palliative Care

Webster Co Health Dept.
Better Choices Better Health

Standardized PH assessments

Health Promotion/Health Maintenance/PH visits

Linking to "Other" PH programs: WIC, Maternal Child Health, Tobacco, Environmental Health, Community Transformation, BASICS, Senior Health

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2011 Integration Year 1-Listened/Learned

- Pioneer ACO project was being discussed and written
- PH communicated to primary care providers services available in the community
- **Community Transformation Grant Initiative-Webster County**
- **Coordinate and collaborate a referral system for children and expecting mothers through the Maternal/Child Health Program- (Title V)**
- Public health was asked to provide input into Pioneer Application
- December 2011 Pioneer ACO Core Steering Committee Formed – WCHD community partner

Integration Year 2
Integration/communication

- WCHD serves on several ACO committees to provide “population” input
- Pediatric Providers integrated a care coordination system with the Maternal/Child Health Title V Program
- Continuum of care for the client - guidance of public health
- ICCDM and Better Choices Better Health
- My Care Profile – standardized public health assessments
- Unity Point at Home – Public health home visitation programs
- Regional approach to integrate services - Public Health Summit
- Continued communication of public health programs integrated into care of the population – Smoking Cessation Programs
- Pioneer ACO mission/vision - Discussed with Local Board of Health

Integration Year 3
Communication and Integration of a structure/system

- Continued committee meetings and sub-committee meetings
- Integrated Health Home “model”
- Asthma Project with primary care providers, school system, public health
- ER Discharge/Readmissions - connecting to public health programs
- Discovered a barrier for some clients to receive immunizations - Coordinated Adult Immunizations/ Hep A & B through public health
- Tobacco screenings - Tobacco Cessation Intervention
- **Non-threatening regional approach to integrate strategies outside of Webster County**
- ICCDM within Pioneer ACO - Public health trained neighboring counties in the Better Choices Better Health curriculum
- **Interfacing software to communicate between public health (possibly regionally) and primary care providers .**
- **Tri-Navigation Initiative – PCP Navigator, Mental Health Navigator and public health navigator**

Webster County
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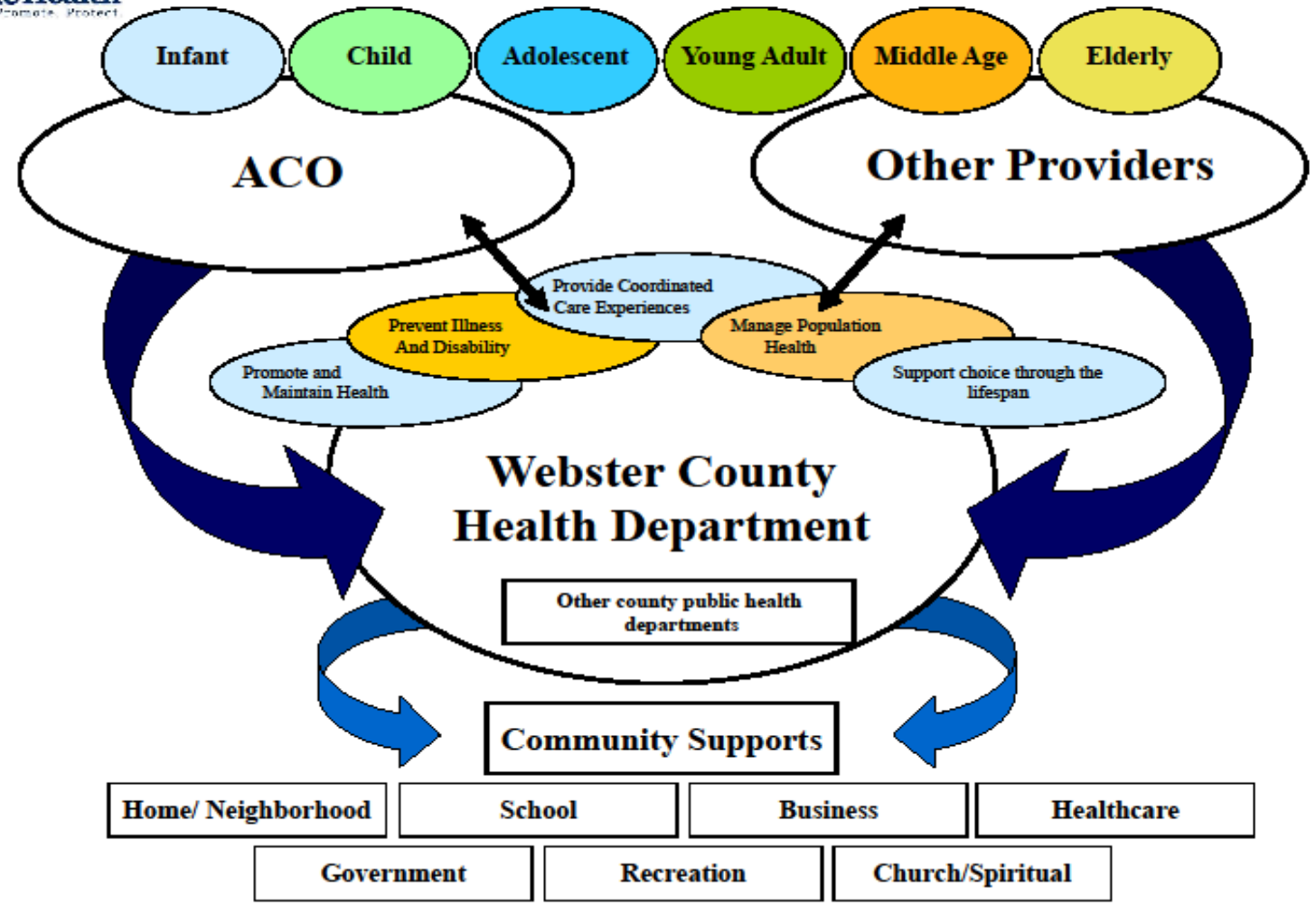
Our Vision

Promote and improve the health, quality of life and environment for Webster County.

The Webster County Health Department is concerned with the health needs of the whole community. Public Health staff work with the community in the home, schools, or businesses. The tradition continues as we offer these services to the PUBLIC.



Webster County ~RESULTS

- Maternal/Child Health Program

January 2011 – March 2012 = 87 referrals

March 2012 –October 2013 = 452 Integrated Care visits

- Public Health Programs Integrated Care visits

January 2011 – June 2012 4clients/6 visits

July 2012- June 2013 41 clients/82 visits

July 2013–October 2013(4mo) 27 clients/ 47 visits

Your Community Care Team

- Your Community Care Team project establishes a comprehensive tri-navigational model (physical, mental, and public/social needs) to coordinate and mobilize healthcare and community resources for our most vulnerable population.
- Collaborative effort by 6 independently governed public health agencies to implement a regional population health strategy: Calhoun, Hamilton, Humboldt, Pocahontas, Webster and Wright counties.
- The overarching goals of this project are to positively impact the health and wellness of our most vulnerable populations by identifying needs, filling existing gaps in services without duplication, and opening channels of communication between service providers to more effectively and efficiently serve our public.

Who is involved?

- Aside from public health agencies, 100% of primary care providers (including the area federally qualified healthcare center) and hospitals in the region have agreed to participate.
- Other participating stakeholders: behavioral health providers, dentists and pharmacists.
- This project has also enlisted numerous community partners: social services, area schools, prisons, and maternal and child health contractors.
- Overall, 37 organizations submitted letters of commitment in support of this project

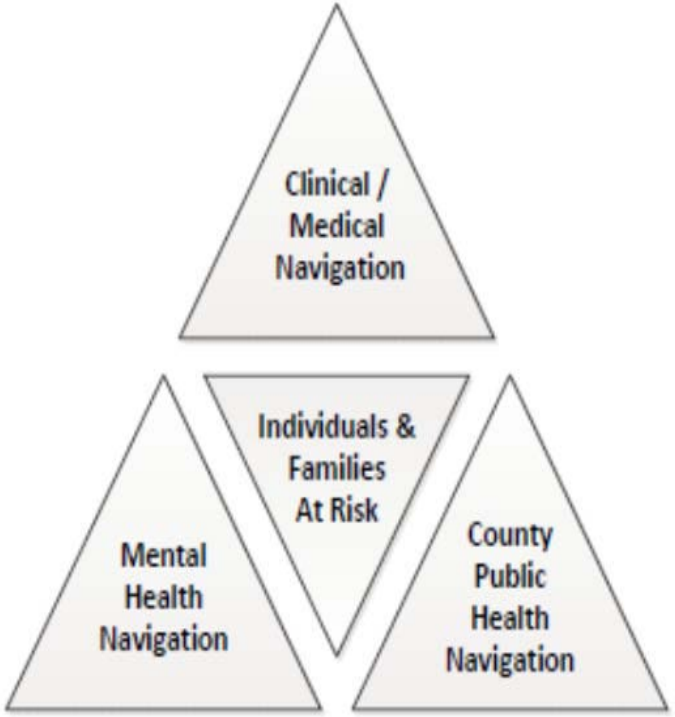
How will we integrate?

- Your Community Care Team will provide care coordination services to approximately 2429 at-risk residents – both those with medically complex conditions and at-risk children.
- A structured Tri-Navigation system, the program will adjust to the needs of individuals by providing appropriate medical homes with distinct supports tailored to the individual and their primary needs– public health, primary care, or behavioral health.
- This Tri-Navigation coordination model wraps around the patient to provide all-inclusive assessments and services regardless of where they present, their primary health need, or required supportive services.
- This model also respects patient choice and their existing relationships with trusted providers by collaborating with and extending the reach of the patient's primary care provider

Your Community Care Team

- The YCC Team will serve as an extension of the Patient Centered Medical Home for the targeted populations.
- The YCC Team will participate in the development individualized care plans and health and psycho-social assessments, assist patients with scheduling and appointments, support health literacy efforts and self-management, and identify and track referrals to community resources.
- Beyond additional “eyes and ears”, this team represents “boots on the ground.” Healthcare professionals may be dispatched to homes to assess patients and families in their environs. Medication reconciliation, food and nutrition assessments, and mobility issues can be addressed.

Tri- Navigation



Navigation from the primary care provider

Navigation from behavioral health

Navigation from the public health/community

Your Community Care Team

Public Health

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Kari Prescott, Director

Webster County Health Department